School Year ______--______

Spring Branch ISD School

Diet Modification Form

PLEASE RETURN FORM TO THE SCHOOL NURSE

Please allow up to 2 weeks for processing. If unable to accommodate, parent will be notified in that time frame. Please complete form in whole.

☐ New Order ☐ Change Order ☐ Discontinue Order ☐ No Changes

Student Information

Student's Name (Last, First):______________________ Date of Birth:______________

School: ______________ Student ID#: ______________ Grade/Teacher: ______________

By signing below, I (Parent/Guardian) acknowledge that it is my responsibility to notify any change in my child's dietary needs in writing on this form. I will send completed form to School Nurse and give Child Nutrition Services consent to make modifications to my child's meals and to speak with the healthcare personnel below to discuss the dietary needs on this form.

Parent/Guardian Signature______________________ Date:______________

Phone Number: ______________________ Email: ______________________

Which meals will the student eat <u>from the school cafeteria?</u> (check all that apply)

☐ Breakfast ☐ Lunch ☐ Snack ☐ None (***if student does not eat from the cafeteria, modifications will not be arranged)***

Medical Information (To Be Completed By A State Licensed Healthcare Professional)

Does the child have a **life-threatening food allergy**? **(check one)** ☐ **No** ☐ **Yes**

Does the child have a **Disability affecting major life activity requiring diet modification**? **(check one)** ☐ **No** ☐ **Yes**

Describe the major life activities affected in relation to dietary modification being request: ______________________

Can the student consume foods where **the allergen is an ingredient**? (Ex: egg in waffles or milk in pancakes)? ☐ **Yes** ☐ **No**

Foods to Omit	**Appropriate Substitute(s)**
☐ All Dairy ☐ Fluid Milk ☐ Cheese	☐ Soy Milk ☐ Dairy as an ingredient in baked items
☐ Gluten ☐ Wheat	☐ Gluten Free Diet ☐ Rice, Corn, other grains
☐ Peanuts ☐ Tree Nuts ☐ Soy	☐ Equivalent Protein
☐ Eggs ☐ Shellfish	☐ Chicken ☐ Beef
☐ Corn ☐ Corn Derivatives	☐ Wheat ☐ Rice, only
☐ Texture (Indicate Consistency)______________ ☐ Liquids (indicate Consistency) ______________	Other: (please specify)______________________
Other (please specify) ______________________	Food Allergy or Intolerance: ☐ Ingestion ☐ Inhalation ☐ Contact

State Licensed Healthcare Professional Information (Physician, Physician Assistant, Advanced Practice Nurse)

Name of Licensed Healthcare Professional (Print):______________________ Phone:______________

Signature of Licensed Medical Professional:______________________ Date:______________

Name of Clinic/Hospital:______________________ Questions? Contact Child Nutrition Services at 713-251-1150

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